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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RALPH ELTON CRANDALL, JR.** **16391 Fir Street** **Hesperia, CA 92345** **Registered Nurse License No. 585256** Respondent.	Case No. 2013-767 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board).

2. On or about August 10, 2001, the Board issued Registered Nurse License Number 585256 to Ralph Elton Crandall, Jr. (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2013, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Code section 2761 provides, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse ... for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

...

7. Code section 2762 provides, in pertinent part:

"In addition to other acts constituting unprofessional conduct ... it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of the law, or prescribe, or except as directed by a licensed physician ... any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug ... as defined in Section 4022."

REGULATORY PROVISIONS

8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure

to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

9. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

COST RECOVERY PROVISION

10. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUG DEFINITION

11. Hydromorphone, trade name Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code Section 11055(b)(1)(J) and a dangerous drug per Business and Professions Code Section 4022. Dilaudid is a trade name for Hydromorphone.

12. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code Section 11055(b)(1)(L) and a dangerous drug per Business and Professions Code Section 4022.

13. Vicodin is among the brand names for compounds of varying dosages of acetaminophen (aka APAP) and hydrocodone, a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4) and a dangerous drug as designated by Business and Professions Code section 4022.

BACKGROUND FACTS

Victor Valley Community Hospital

14. Beginning in 2005, Respondent began employment as a registry nurse through Reliable Nursing Solutions.

15. During the time period between 7/14/10 and 3/24/11, Respondent was employed as a registry nurse at Victor Valley Community Hospital (VVCH) where he worked in the Intensive Care Unit (ICU).

16. On or around 3/21/11, 69 year-old patient A.C.[1] (Patient), was admitted to VVCH for Aortic Occlusive Disease and was scheduled for aoroticbifemoral bypass graft.

17. After surgery, Patient was transferred to ICU where he was intubated due to occlusion of the right limb of the graft.

18. From the ICU, Patient was taken back to the operating room where the right limb was declotted. After declotting, Patient regained pulsation throughout the right limb.

19. After surgery, Patient's medical condition changed: Patient required the use of a ventilator to aid in breathing; Patient's heart rhythm indicated a decrease in blood flow to the heart muscle; Patient suffered hypotensive crisis and developed acute renal failure.

20. Due to Patient's hypotensive condition, Patient was prescribed a dopamine infusion[2] to increase blood pressure.

21. Instead, Respondent administered nitroglycerin infusion[3].

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[1] Initials are used to protect patient confidentiality.

[2] A dopamine drip is an intravenous administration of diluted dopamine used to increase blood flow to the internal organs and raise blood pressure. Doctors typically recommend dopamine drips for patients at risk of shock caused by low blood pressure.

[3] A nitroglycerin drip is an intravenous administration of diluted nitroglycerin used to dilate blood vessels in order to decrease blood pressure and thus reduce the load on the heart. This medication is not considered safe for use in patients with low blood pressure, or for those who have lost large volumes of blood.

22. Respondent admitted that he failed to read the label of the bottle and as a consequence he "hung the wrong medication".

23. Respondent admitted that he failed to document the administration of nitroglycerin.

24. Respondent admitted that he failed to follow all 7 Rights regarding patient drug administration which include: 1. The right prescribed drug; 2. The right prescribed dosage and strength; 3. The right rate and route of administration; 4. The right patient; 5. The right prescribed frequency; 6. The right prescribed time for medicine administration; 7. The right drug indicated for the patient;

25. Patient received the nitroglycerin infusion for several hours before the problem was identified by a physician and subsequently corrected.

26. As a result of Respondent's actions, Patient experienced circulatory changes, shock and a deteriorating health condition which resulted in cardiac arrest.

27. Patient's family decided that Patient would not receive cardio pulmonary resuscitation if Patient's heart and breathing stopped.

28. Patient died two days later on 3/24/11.

29. Respondent was identified by VVCH as a "Do Not Return". Respondent was subsequently terminated from employment with Reliable Nursing Solutions.

Desert Valley Hospital

30. During the time period between 3/5/08 and 6/3/11, Respondent was employed as a registry nurse at Desert Valley Hospital (DVH).

31. An investigation and review of the Pyxis System[4] records relating to Respondent's withdrawals of medication revealed medication discrepancies in documentation as set forth below:

PATIENT A

	CONTROLLED SUBSTANCES WITHDRAWN
5/9/11	**Physician orders for Dilaudid 0.5 mg IV Q6h prn**
9:44 a.m.	Administration not documented in nursing notes; no waste documented
1:23 p.m.	No waste documented. Not given per doctor's orders (medication pulled too soon)
5:5? p.m. (illegible)	No waste documented. Not given per doctor's orders (medication pulled too soon)
5/10/11	**Physician orders for Dilaudid 0.5 mg IV Q6h prn**
7:32 a.m.	No waste documented. Not given per doctor's orders (medication pulled too soon)
9:38 a.m.	No waste documented. Not given per doctor's orders (medication pulled too soon)
1:16 p.m.	No waste documented. Not given per doctor's orders (medication pulled too soon)

SUMMARY: Respondent failed to administer Dilaudid to this patient in accordance with physician's orders. Respondent withdrew at total of 12 mg of Dilaudid, well in excess of the prescribed dosage and failed to document waste. Respondent failed to explain why he did not follow doctor's orders, but admitted this mistake was "inexcusable."

PATIENT B

	CONTROLLED SUBSTANCES WITHDRAWN
4/30/11	**Physician orders for morphine 2 mg IV Q4h prn severe pain**
7:26 a.m.	Not documented in E-MAR, not documented in nursing notes

[4] Pyxis is a computerized automated medication dispensing machine. The machine records the user name, patient name, medication, dose, date and time of the withdrawal. The Pyxis is integrated with hospital pharmacy inventory management systems.

11:28 a.m.	Not documented in E-MAR, not documented in nursing notes
5/2/11	**Physician orders for morphine 2 mg IV Q4h prn severe pain**
7:50 a.m.	Not documented in E-MAR, not documented in nursing notes
5/4/11	**Physician orders for morphine 2 mg IV Q4h prn severe pain**
3:52 p.m.	Not documented in E-MAR, not documented in nursing notes

SUMMARY: Respondent failed to document administration of controlled substances in E-MAR or in his nursing notes. Respondent failed to explain why he failed to properly document, but admitted that his failure to do so was "mostly sloppy."

32. In addition, during the time period between 5/23/11 – 5/25/11, Respondent withdrew various narcotics without obtaining a witness as required.

33. Respondent also removed medications from DVH Med/Surg East wing Pyxis which Respondent failed to document as administered in Meditech.

34. Respondent failed to submit a urine test as requested, however Respondent admitted that he "would not pass" the test because he was taking his wife's prescription for Vicodin, a controlled substance.

35. Respondent was terminated from employment at DVH on 6/3/11.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Incompetence)

36. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the grounds of unprofessional conduct as defined under California Code of Regulations, title 16, sections 1443 and 1443.5, in that while working for VVCH and DVH as a registry nurse, Respondent failed to exercise the degree of learning, skill, care and experience ordinarily

possessed and exercised by a competent registered nurse. Complainant incorporates by reference paragraphs 14 – 35 as if fully set forth herein.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

37. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the grounds of gross negligence as defined under California Code of Regulations, title 16, section 1442, in that while working for VVCH and DVH as a registry nurse, Respondent demonstrated an extreme departure from the standard of care, which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse relating to the administration and documentation of administered medications. Complainant incorporates by reference paragraphs 14 – 35 as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Negligence)

38. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the grounds of unprofessional conduct in that Respondent committed acts constituting negligence. Complainant incorporates by reference paragraphs 14 – 35 as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Obtaining Controlled Substances)

39. Respondent is subject to discipline under Code section 2762, subdivision (a) on the grounds of unprofessional conduct relating to controlled substances or dangerous drugs and as

defined in the relevant Health and Safety and Business and Professions code. Complainant incorporates by reference paragraphs 33 – 35 as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

40. Respondent is subject to discipline under Code section 2761, subdivision (a) in that while working for VVCH and DVH as a registry nurse, Respondent committed acts constituting unprofessional conduct. Complainant incorporates by reference paragraphs 14 – 35 as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 585256, issued to Ralph Elton Crandall, Jr.

2. Ordering Ralph Elton Crandall, Jr. to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: March 14 2013

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
State of California
Complainant

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